

Plan of Correction

Program Name: Wellspring Inc., dba Wellfully	Date Submitted: 4/12/2021	Date Due: 4/26/2021
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Administrative POC-1		
Rule #: 67:61:04:01	Rule Statement: Policies and procedures manual. Each agency shall have a policy and procedure manual to establish compliance with this article and procedures for reviewing and updating the manual.	
Area of Noncompliance: Wellfully does not have procedures for reviewing and updating their policies and procedures manual.		
Corrective Action (policy/procedure, training, environmental changes, etc): We have added a policy around a procedure relating to updating and refining our policies.		Anticipated Date Achieved/Implemented: Date April 2021
Supporting Evidence: See attached Policy and Procedures Record of Care and Services page 1. Policy review Process We have established a continuous quality review committee that will review various aspect of our operations and procedures each quarter or more frequently as needed. The complete review of the policy manual will be done each year in March and updates published on or online manual. As audits and reviews bring to our attention adjustments will be done sooner.		Position Responsible: W. Burke Eilers
How Maintained: Annual review as per new policy. The board will be notified at our next meeting as to recent changes.		Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-2		
Rule #: 67:61:02:20	Rule Statement: Changes Requiring Notification. An accredited agency shall notify the division director before: a change in the agency director, a reduction in services provided by the agency, or an impending closure of the agency for a determination on continued accreditation. An accredited agency shall give the division 30 days written notice of closure. The agency shall provide the division written documentation ensuring safe storage of financial records for at least six years from the date of closure, and of client case records for a minimum of six years from closure required by 42 C.F.R. § 2.19 (June 9, 1987), disposition of records by discontinued programs. The division may assist in making arrangements for the continuation of services to clients by another accredited agency before the closing.	
Area of Noncompliance: Wellfully does not have policy to contact the Division Director prior to change in agency director, reduction in services provided by the agency, and/or the impending closure of the agency.		
Corrective Action (policy/procedure, training, environmental changes, etc): Our policies have been amended to reflect this request and Rule. “Wellfully will notify the division director of DSS Behavioral Health before: a		Anticipated Date Achieved/Implemented:

change in the agency director, a reduction in services provided by the agency, or an impending closure of the agency for a determination on continued accreditation. Wellfully will give the division 30 days written notice of temporary or permanent closure. If there is an unexpected need to close the facility temporarily or permanently, we will coordinate with DSS Behavioral Health the placing of any youth in alternative locations. “	Date 4/12/21
Supporting Evidence: See attached Policies and procedures of Human Resources page 1.	Position Responsible: Mandi Johnson
How Maintained: We have adjusted our policies and notified our finance and HR staff.	Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-3	
Rule #: 67:61:02:21	<p>Rule Statement: Sentinel event notification. Each accredited agency shall make a report to the division within 24 hours of any sentinel event including; death not primarily related to the natural course of the client’s illness or underlying condition, permanent harm, or severe temporary harm, and the intervention required to sustain life.</p> <p>The agency shall submit a follow-up report to the division within 72 hours of any sentinel event and the report shall include:</p> <ol style="list-style-type: none"> 1. A written description of the event; 2. The client’s name and date of birth; and 3. Immediate actions taken by the agency. <p>Each agency shall develop root cause analysis policies and procedures to utilize in response to sentinel events.</p> <p>Each agency shall also report to the division as soon as possible: any fire with structural damage or where injury or death occurs, any partial or complete evacuation of the facility resulting from natural disaster, or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours.</p>
Area of Noncompliance: Wellfully does not have a policy to report sentinel events to the division. Wellfully also does not have a root cause analysis policy to respond to sentinel events. Lastly, Wellfully does not have a policy to report to the division about fire with structural damage or where injury or death occurs, partial or complete evacuation resulting from natural disaster, or loss of utilities for more than 24 hours.	
Corrective Action (policy/procedure, training, environmental changes, etc): Please see the attached Policies and Procedures for Care and Treatment page 13. Our policy was not clear as to the reporting of a Sentinel event we did add the review process and made the reporting requirements more clear.	Anticipated Date Achieved/Implemented: Date April 2021
Supporting Evidence: Reportable sentinel events include: Sentinel event notification. Wellspring shall make a report to the division within 24 hours of any sentinel event including; death not primarily related to	Position Responsible: Rich Cartney Bryan Satterwhite

<p>the natural course of the client's illness or underlying condition, permanent harm, or severe temporary harm, and the intervention required to sustain life.</p> <p>As part of our reporting, we conduct a management review of the event to determine root cause and review of changes or modifications need to be made.</p> <p>Wellspring shall submit a follow-up report to the division within 72 hours of any sentinel event and the report shall include:</p> <ol style="list-style-type: none"> 1. A written description of the event; 2. The client's name and date of birth; and 3. Immediate actions taken by the agency. <p>We will develop root cause analysis policies and procedures to utilize in response to sentinel events.</p> <p>Wellspring will report to the division as soon as possible: any sentinel event, fire with structural damage or where injury or death occurs, any partial or complete evacuation of the facility resulting from natural disaster, or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours.</p> <p>The individualized plan of action to address the reasons for retaining the individual in the present level of care shall be documented every:</p> <ol style="list-style-type: none"> a. Two calendar days for clinically managed residential detoxification; b. 14 calendar days for early intervention services, intensive outpatient services, day treatment services, and medically monitored intensive inpatient treatment; and c. 30 calendar days for outpatient treatment program and clinically managed low intensity residential treatment. 	
<p>How Maintained: If additional changes are required, they will be modified thorough our review process.</p>	<p>Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Administrative POC-4	
<p>Rule #: 67:61:05:01</p>	<p>Rule Statement: Tuberculin Screening Requirements. Tuberculin screening requirements for employees are as follows:</p> <ol style="list-style-type: none"> 1. Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not

	<p>required if documentation is provided of a previous position reaction to either test;</p> <ol style="list-style-type: none"> 2. A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; 3. Each staff member, intern, and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of <i>Myobacterium tuberculosis</i>. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and 4. Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.
<p>Area of Noncompliance: Wellfully does not have policy regarding the two step TB test for new employees or subsequent requirements. Additionally, four out of five applicable employee files reviewed did not have record of first or second TB tests.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): We did make the adjustments to our TB policies as per the recommendations of the review team.</p>	<p>Anticipated Date Achieved/Implemented:</p> <p>Date 4/28/21</p>
<p>Supporting Evidence: Page 7-8 in the Policies and Procedures Human Resources manual. Medical conditions / requirements:</p> <p>1.Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test; if documentation of a positive reaction to the tuberculin skin test or TB blood assay test is provided a medical evaluation and chest X-ray is needed to determine the presence or absence of the active disease;</p> <p>3. If there is a positive reaction to the tuberculin skin test or TB blood assay test the staff member shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of myobacterium tuberculosis. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.</p>	<p>Position Responsible:</p> <p>Nursing Staff</p>

4. As conditions warrant staff maybe required to show proof of immunization related to COVID19 or maybe required to have a face mask at all time while at work in the facility. Annual flu shots are required or they is the requirement of having a face mask on at all times.	
How Maintained: At the time of hire the new process will be done. We are currently conducting this process to current staff. It will be started as soon as we receive needed supplies.	Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-5	
Rule #: 67:61:07:04	Rule Statement: Closure and storage of case records. The agency shall have written policies and procedures to ensure the closure and storage of case records at the completion or termination of a treatment program including: <ol style="list-style-type: none"> 1. The identification of staff positions or titles responsible for the closure of case records within the agency and the MIS; 2. Procedures for the closure of inactive client records, that are clients who have not received services from an inpatient or residential program in three days or clients who have not received services from an outpatient program in 30 days. 3. Procedures for the safe storage of client case records for at least six years from closure.
Area of Noncompliance: Wellfully does not have policies and procedures ensuring the closure and storage of case records	
Corrective Action (policy/procedure, training, environmental changes, etc): Please see Policy and Procedures Record Care page 5. We did have the policy in place but we did not find it at the time of the review.	Anticipated Date Achieved/Implemented: Date April 2021
Supporting Evidence: 67:61:07:04. Closure storage and maintenance of client case records. This agency shall maintain a case record for each client. The case record shall describe the services provided and the client's progress in the program. The case record for residential programs shall include the client's physical and mental health status at the time of admission. The client record shall provide information for the review and evaluation of the treatment provided to the client. Wellspring has an Electronic Medical Record System. Our policies and procedures restrict access to the client files based on need. Outside access is determined by a signed release of information form and or a signed court order by a judge the details of the restrictions can be found in our intake packet and supporting HIPPA related materials. We have restricted access to the EMR and it is controlled and supervised by the clinical director and based on need to know. Any and all paper files are kept double locked, and access is restricted to staff that meet the need to know criteria. All records are kept for a period of 8 years after turning 18. The staff positions or titles responsible for the closure of case records within the agency and the EMR include the CEO, CFO, COO clinical supervisor, our intake specialist and counseling staff as warranted. Any exceptions are approved by the clinical director. Certain public agencies will be afforded routine access by virtue of the responsibilities of control, accountability and investigation of agency conduct established in state and federal regulations. Auditors, licensing personnel and protection teams are examples of public agencies with routine access to records. Access granted to any of these individuals will be documented on the client record. Any access provided to those persons representing public agencies will be monitored	Position Responsible: Rich Cartney Bryan Satterwhite

<p>and limited only to data related to the subject matter of their respective investigation. Client records will be reviewed periodically for uniformity of format and completeness of content by the Clinical/Program Director or his designee.</p> <p>The Executive Director may in some instances grant access to client records for the purpose of evaluation and assessment of agency practices such as by paid consultants or for the purpose of accreditation by outside professional representatives that are bound by ethical and professional standards of confidentiality.</p> <ul style="list-style-type: none"> • The client file is closed if inactive or the client has not received services from an inpatient or residential program in three days or clients who have not received services from an outpatient program in 30 days. The files are maintained after services have ended for a eight year period after turning 18. • Ensure that case records, paper or electronic copy, are protected against loss, tampering, or unauthorized disclosure of information, in accordance with 42 U.S.C. §§ 290 dd-2 and 42 C.F.R., Part 2 (June 9, 1987), and 45 C.F.R., Part 160 and 164 (April 17, 2003); • Maintain our EMR client record keeping system; • Ensure that all entries in case records are legible, dated, and signed by the person making the entry with their credentials; and • Upon closure each file shall be reviewed for all client case records for required content, uniformity of format and completeness of content, by the admission specialist. • In addition to Quality of Care Reviews each addiction counselor trainee shall have 1 client file reviewed in full each week with the clinical supervisor, during their scheduled individual supervision time. 	
<p>How Maintained: All policies are reviewed annual.</p>	<p>Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Administrative POC-5	
<p>Rule #: 67:61:05:12</p>	<p>Rule Statement: Office of Inspector General Medicaid exclusion list. Each agency shall routinely check the Office of Inspector General's List of Excluded Individuals and Entities to ensure that each new hire as well as any current employee is not on the excluded list. No payment may be provided for services furnished by an excluded individual. Documentation that this has been completed shall be placed in the employee's personnel file.</p>
<p>Area of Noncompliance: Wellfully does not have a policy to contact the Division Director prior to change in agency director, reduction in services provided by the agency, and/or the impending closure of the agency.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): Policy was adjusted to reflect the ongoing review of the Exclusion list, this will be done annually at the time of our annual reviews.</p>	<p>Anticipated Date Achieved/Implemented: Date April 2021</p>
<p>Supporting Evidence: Policy and Procedures Human Resources manual page 8. ARSD 67:61:05:12 Wellfully upon hiring and on an annual basis at the time of their annual review Wellfully will check the Office of Inspector General's List of Excluded Individuals and Entities to ensure that each new hire as well as any current employee is not on the excluded list. Documentation that this has been completed shall be placed in the employee's personnel file.</p>	<p>Position Responsible: Mandi Johnson</p>
<p>How Maintained: Change in process at hiring and after annual review.</p>	<p>Board Notified: xY <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Client Chart POC-1

Rule #: 67:61:07:05 (11)	Rule Statement: Integrated Assessment: An addiction counselor or counselor trainee shall meet with the client and the client's family if appropriate, to complete an integrated assessment, within 30 days of intake. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and shall assess the client's treatment needs. The assessment shall be recorded in the client's case record and includes the following component: 11. Past or current indications of trauma, domestic violence, or both if applicable.
Area of Noncompliance: Three out of seven assessments reviewed did not have documentation of past or current trauma or domestic violence, or lack thereof	
Corrective Action (policy/procedure, training, environmental changes, etc): The existing policy was reviewed and need adjustments made. We added the statement on trauma. This will be brought to the attention of the counseling staff.	Anticipated Date Achieved/Implemented: Date April 2021
Supporting Evidence: See policies and Procedures manual of Record of Care page 3. 67:61:07:05. Standardized Initial Integrated Assessment. A chemical dependency counselor or counselor trainee shall complete an assessment or updated assessment approved by the division for each client admitted to Level III.7 medically-monitored intensive inpatient treatment program for adolescents or adults, Level III.1 clinically-managed low-intensity residential treatment program, Level II.1 intensive outpatient treatment program, Level II.5 day treatment program, or Level I.0 outpatient services program. The assessment shall establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and shall assess the client's treatment needs. The initial assessment shall include the following components: Department of Social Services Division of Behavioral Health STARS User Manual ADA II Page 82 of 115 Updated: 2014 An addiction counselor or counselor trainee shall meet with the client and the client's family if appropriate, to complete an integrated assessment, within 30 days of intake. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and shall assess the client's treatment needs. The assessment shall be recorded in the client's EMR and includes the following component: (1) Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable; (2) Presenting problems or issues that indicate a need for services; (3) Identification of readiness for change for problem areas, including motivation and supports for making such changes; (4) Relevant treatment history, including attention to previous mental health and substance abuse/gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or	Position Responsible: Bryan Satterwhite W. Burke Eilers

<p>potential for relapse, physical illness, and hospitalization;</p> <p>(5) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history;</p> <p>(6) There should be a discussion related to and documentation of past or current trauma or domestic violence, or lack thereof.</p> <p>(7) Family and relationship issues along with social needs;</p> <p>(8) Educational history and needs;</p> <p>(9) Legal issues;</p> <p>(10) Living environment or housing;</p> <p>(11) Safety needs and risks with regards to physical acting out, health conditions, acute intoxication, or risk of withdrawal;</p> <p>(12) Past or current indications of trauma, domestic violence, or both if applicable;</p> <p>(13) Vocational and financial history and needs;</p> <p>(14) Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present;</p> <p>(15) Formulation of a diagnosis per DSM-V, including documentation of co-occurring medical, developmental disability, mental health, substance abuse, or gambling issues or a combination of these based on integrated screening;</p> <p>(16) Eligibility determination, including ASAM level of care determination for substance abuse services and/or;</p> <p>(17) Eligibility determination, including documentation regarding sufficient information to determine SMI or SED for mental health services;</p> <p>(18) Document the clients current level of functioning; Department of Social Services Division of Behavioral Health</p> <p>STARS User Manual ADA II Page 83 of 115 Updated: 2014</p> <p>(19) Clinician's signature, credentials, and date; and</p> <p>(20) Clinical supervisor's signature, credentials, and the date verifying review of the assessment and agreement with the initial diagnosis or the formulation of the initial diagnosis in cases where the staff does not have the education and training to make a diagnosis.</p> <p>Any information related to the standardized treatment needs assessment shall be verified through collateral contact, if possible, and recorded in the client's case record.</p> <p>Any staff completing an Integrated Initial Assessment shall be required to provide documentation of client and family strengths in the specified sections. The clinical director shall assure compliance, by requiring this standard in the quarterly Quality of Care reviews.</p>	
<p>How Maintained: Annual review process. And our ongoing file review process.</p>	<p>Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Client POC-2	
<p>Rule #: 67:61:07:07</p>	<p>Rule Statement: Continued Service Criteria. The program shall document for each client the progress and reasons for retaining the client at the present level of care; and an individualized plan of action to address the reasons for the retaining the individual in the</p>

	<p>present level of care. This document is maintained in the client case record. It is appropriate to retain the client at the present level of care if:</p> <ol style="list-style-type: none"> 1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 3. New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the client is receiving treatment is therefore, the least intensive level at which the client's new problems can be addressed effectively. <p>The individualized plan of action to address the reasons for retaining the individual in the present level of care shall be documented every:</p> <ol style="list-style-type: none"> a. Two calendar days for clinically-managed residential detoxification; b. 14 calendar days for early intervention services, intensive outpatient services, day treatment services, and medically monitored intensive inpatient treatment; and c. 30 calendar days for outpatient treatment program and clinically managed low intensity residential treatment.
<p>Area of Noncompliance: All eight applicable files reviewed were missing continued stay criteria in the following ways:</p> <ol style="list-style-type: none"> 1. Documentation of the client meeting the continued service criteria for level 2.1 was not documented at least every 14 days. 2. There was no documentation of progress and reasons for retaining the client in the present level of care. 3. The individual plan of action did not address the reasons for retaining the client in the present level of care. 	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): The policy was in place, but the electronic medical records were not updated in a timely manner. This has been addressed with our IOP instructor and a monthly review as to compliance will be made.</p>	<p>Anticipated Date Achieved/Implemented:</p> <p>Date April 30,2021</p>
<p>Supporting Evidence: See our Policy and Procedure manual of the Record of Are Page 8. Rule Statement: Continued Service Criteria. For clients on the ARU or attending IOP classes The program shall document for each client the progress and reasons for retaining the client at the present level of care; and an individualized plan of action to address the reasons for the retaining the individual in the present level of care. This document is maintained in the client EMR case record. It is appropriate to retain the client at the present level of care</p>	<p>Position Responsible:</p> <p>Jason James Bryan Satterwhite and W. Burke Eilers</p>

<p>if:</p> <ol style="list-style-type: none"> 1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 3. New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the client is receiving treatment is therefore, the least intensive level at which the client's new problems can be addressed effectively. <p>The individualized plan of action to address the reasons for retaining the individual in the present level of care shall be documented every:</p> <ol style="list-style-type: none"> a. Two calendar days for clinically-managed residential detoxification; b. 14 calendar days for early intervention services, intensive outpatient services, day treatment services, and medically monitored intensive inpatient treatment; and c. 30 calendar days for outpatient treatment program and clinically managed low intensity residential treatment. 	
<p>How Maintained: The electronic records must be updated weekly and reviewed monthly.</p>	<p>Board Notified: Yx <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

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